Claim for Compensation On Account of Traumatic Injury or Occupational Disease

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee Statement

OMB No. 1215-0103
Expires: 10-31-99

1. Name of Employee — Last / First / Middle

2. OWCP File Number

3. Social Security Number

4. Period of wage loss for which compensation is claimed — From mo. day yr. Thru mo. day yr. — Hours

5. Is this a claim for a schedule award? ☐ Yes ☐ No

6. Has any pay been received for period shown in item 4? ☐ Yes ☐ No

7. If yes, amount — From mo. day yr. Thru mo. day yr.

8. Complete this item if you worked during the period shown in item 6. Attach a separate sheet if needed.

a. Salaried Employment,

Dates & Hours Worked	Pay Rate (Per hour, day or week)	Total Amount Earned	Type Work Performed	Name & Address of Employer

b. Commission and Self-Employment. Show all activities, whether or not income resulted from your efforts.

Dates & Hours Worked	Name and Address of Business	Self-Employed ☐ Commission ☐	Type of Activity Performed	Income Derived (Attach Explanation if Needed)

9. Was claim made against 3rd party? ☐ Yes ☐ No

10. Name of 3rd party or insurance carrier

Address

11. Has the claim been settled? Give amount recovered.

City / State / ZIP

12. Have you ever applied for or received benefits from the Veterans Administration based on disability incurred while serving in the Armed Forces of the United States? ☐ Yes ☐ No If Yes, furnish <	a. Claim number	b. Address of VA office where claim is filed	c. Nature of disability and monthly payment

13. Have you applied for or received an annuity under the U.S. Civil Service Retirement Act or any other Federal Retirement or Disability Law? ☐ Yes ☐ No If Yes, furnish <	a. Claim number	b. Date annuity began mo. day yr.	c. Amount of monthly payment

Dependents

14. List your dependents

Name	Date of Birth mo. day yr.	Relationship	Living with you?	Mailing Address, if different from your own

15. Support Information for above dependents
Are you making support payments for a dependent shown above? ☐ Yes ☐ No

16. Were support payments ordered by a court? If so, attach copy of court order. ☐ Yes ☐ No

17. If yes, support payments are made to: Last / First / Middle

18. Amount Per

Street / City / State / ZIP

Signature of Employee

19. I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed, and every statement above is true to the best of my knowledge and belief.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation as provided by the FECA, or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

Employee's signature — Date (Mo., day, year)

20. Employee's home mailing address (Include Zip Code)
Street / City / State / ZIP

Statement of Official Superior

21. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)
Date of Injury	$ per	$ per	$ per	$ per
Date Employee Stopped Work	$ per	$ per	$ per	$ per

22. If employee received additional pay, identify type and show amount

☐ Premium Pay ____ per ____ ☐ Night Pay ____ per ____

☐ Sunday Pay ____ per ____ ☐ Other (Identify) ____ per ____

23. Show work schedule for week pay stopped
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

24. Did employee work in position for 11 months prior to injury? ☐ Yes ☐ No

25. If not, would position have afforded employment for 11 months but for the injury? ☐ Yes ☐ No

26. Total length of federal civilian service Yrs. ____ Mos. ____

Health Benefits and Optional Life Insurance

27. Was the employee enrolled in a Health Benefits Program at first opportunity, or for 5 years prior to the date pay stopped? ☐ Yes ☐ No

If yes, give code ____

Ending date of the pay period in which HBS / OLI Deductions were last made? mo. day yr. ____

28. Was the employee enrolled in an Optional Life Insurance Program on the date pay stopped? ☐ Yes ☐ No

If yes, was employee enrolled in Option ☐ A ☐ B ☐ C

If Option B, show number of multiples ____

Leave and Continuation of Pay

29. Type and inclusive dates employee received leave for any part of period since stopping work. Specify type of leave, SICK, ANNUAL, or OTHER

Type of Leave	From mo. day yr.	Thru mo. day yr.	Type of Leave	From mo. day yr.	Thru mo. day yr.
Type of Leave	From	Thru	Type of Leave	From	Thru

30. If employee received continuation of pay (COP), give dates.

31. Date all pay stopped mo. day yr. ____ Hour ☐ AM ☐ PM

32. Period for which compensation is claimed From mo. day yr. ____ Thru mo. day yr. ____

Return to Duty

33. Date returned to work mo. day yr. ____ Hour ☐ AM ☐ PM

34. Work schedule when returned to work
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

35. Did the work assignment change because of disability resulting from the injury? Describe. ☐ Yes ☐ No

36. Pay rate on return to work $ ____ Per ____

Certification

37. A supervisor who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Signature of supervisor ____ Date ____

Supervisor's title ____

Agency name & address ____ Office phone ____

38. If OWCP needs specific pay information the person who should be contacted is ☐ Supervisor ☐ Other: Name ____ Phone ____

INSTRUCTIONS FOR COMPLETING CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

EMPLOYEE (or person acting on the employee's behalf) - Complete items 1 through 20 and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete items 21 through 38 and promptly forward the form to OWCP.

ITEM EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Item Number		Explanation
4)	Period of Wage Loss for which Compensation is Claimed	Enter inclusive dates covering the period for which you are claiming compensation. If intermittent periods are claimed, use a separate sheet to list each period individually.
5)	Is This a Claim for a Schedule Award?	Schedule awards are paid for permanent impairment to a member or function of the body. A claim for a schedule award should not be made on the same form as a claim for compensation for wage loss; rather, a separate CA-7 should be used.
6)	Has Any Pay Been Received for Period Shown in Item 4?	This question includes leave pay and COP received from the Federal job in which you were injured; and pay for work actually performed, whether at the Federal job in which you were injured or at other employment (including self-employment).
7)	If Yes, Amount	Give the amount of pay received and the period for which it was paid. If there is more than one period, or more than one source of pay, explain fully on a separate sheet.
9)	Was Claim Made Against 3rd Party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
14)	List Your Dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-time student; or 3) is incapable of self-support due to physical or mental disability.
22)	If Employee Received Additional Pay, Identify Type and Show Amount	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
29)	Type and Inclusive Dates Employee Received Leave for Any Part of Period Since Stopping Work	Enter inclusive dates covering each period of leave. If leave was used for more than four individual periods, continue on a separate sheet. If leave was used for part of each day during a period, state how many hours were used per day; if the number of hours used per day varied, use a separate sheet to list each day.
30)	Dates of Pay Continuation (COP) During Period of Disability	Enter the period of Continuation of Pay (see form CA-1 for a full explanation). If the injury was not a traumatic injury reported on form CA-1, this item does not apply.
31)	Date All Pay Stopped	No compensation is payable for temporary total disability until the employee enters a non-pay status; therefore, item 30 refers to termination of all pay, including leave. Compensation is not payable for the first three days of disability after the end of any COP unless the disability exceeds 14 calendar days.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W., Wash., D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association **Guides to the Evaluation of Permanent Impairment.**

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is required by P.L. 103-296 108 Stat. 1464. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.